PEDIATRIC

BASIC LIFE SUPPORT GUIDELINE

RESPIRATORY DISTRESS, FAILURE OR ARREST

A patient that presents with acute respiratory distress of sudden onset accompanied by fever, drooling, hoarseness, stridor, and tripod positioning may have a partial airway obstruction. ***Do nothing to upset the child.*** *Perform critical assessments only. Enlist the parent to administer blow-by oxygen. Place the patient in a position of comfort. Transport immediately.*

INDICATIONS: Respiratory Distress

- alert, irritable, anxious
- stridor
- audible wheezing
- respiratory rate faster than normal for age
- intercostal retractions
- nasal flaring
- neck muscle use
- central cyanosis that resolves with oxygen administration
- mild tachycardia
- able to maintain sitting position (children older than four months)

INDICATIONS: Respiratory Failure

The above findings with any of the following additions or modifications:

- sleepy, intermittently combative, or agitated
- increased respiratory effort at sternal notch
- marked use of accessory muscles
- retractions, head bobbing, grunting
- central cyanosis
- marked tachycardia
- poor peripheral perfusion
- decreased muscle tone

INDICATIONS: Respiratory Arrest

The findings above with any of the following additions or modifications:

- unresponsive to voice or touch
- absent or shallow chest wall motion
- absent breath sounds
- respiratory rate slower than 10 breaths per minute
- weak to absent pulses
- bradycardia or asystole
- limp muscle tone
- unable to maintain sitting position (children older than four months)

PEDIATRIC

Procedure

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.

3. Form a general impression of the patient's condition. Consider transport plan based on general impression.

4. Observe standard precautions.

5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.

6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction. Signs may include:
   - absent breath sounds
   - tachypnea (persistent rapid respirations)
   - intercostal retractions
   - stridor or drooling
   - choking
   - bradycardia
   - cyanosis

7. If foreign body obstruction of the airway is suspected, refer to Foreign Body Airway Obstruction Guideline.

8. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.

9. Suction as necessary.

10. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.

11. Assess the patient's breathing, including rate, auscultation, inspection, effort, and adequacy of ventilation as indicated by chest rise. If trained, obtain pulse oximeter reading.

12. If chest rise indicates inadequate ventilation, reposition airway and reassess.

13. If inadequate chest rise is noted after repositioning airway, suspect a foreign body obstruction of the airway. Refer to the *Foreign Body Airway Obstruction Guideline.*

14. Assess for signs of respiratory distress, failure, or arrest. If signs of respiratory failure or arrest are present, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. *See Figure 25: E-C Clamp*

15. If breathing is adequate and patient exhibits signs of respiratory distress, administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.

16. If bronchospasm is present and patient has a prescribed inhaler, refer to the *Prescribed Inhaler Guideline.*

17. Assess circulation and perfusion.

18. Assess mental status.

19. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.

20. Initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.

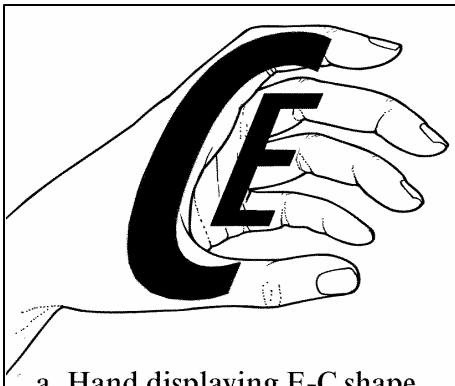
21. Reassess the patient frequently.

22. Contact medical direction for additional instructions.

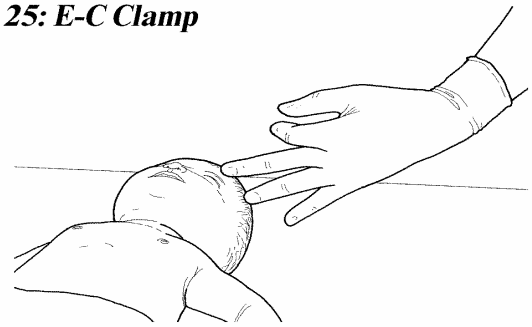
Normal Respiratory Rates

Age	*RR*
Infant (birth–1 year)	30–60
Toddler (1–3 years)	24–40
Preschooler (3–6 years)	22–34
School-age (6–12 years)	18–30
Adolescent (12–18 years)	12–16

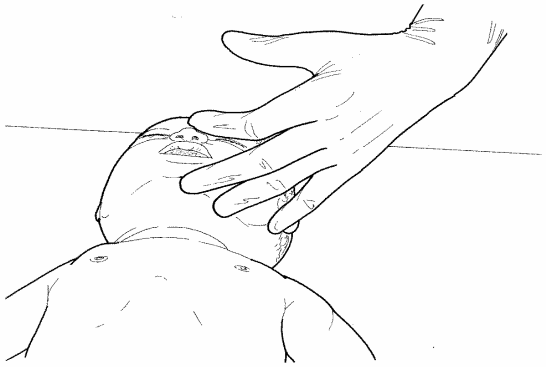
Figure 25: E-C Clamp



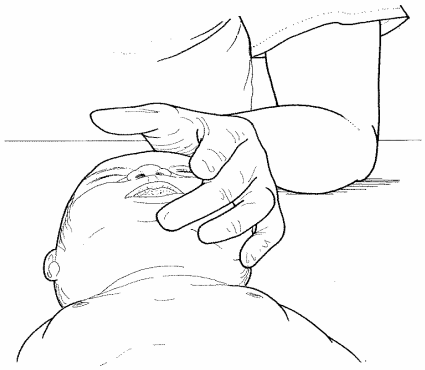
a. Hand displaying E-C shape



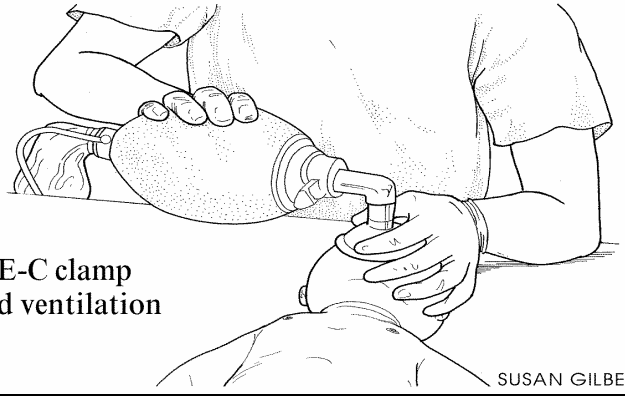
b. E formed with small, ring, and middle fingers; C formed with index finger and thumb



c. E fingers resting on bony ridge of jaw



d. C fingers positioned to hold mask



e. Proper E-C clamp for assisted ventilation

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The Idaho EMSC Project has taken extreme caution to ensure all information is accurate and in accordance with professional standards in effect at the time of publication. This guideline is for reference and may be modified at the discretion of the EMS Medical Director. It is recommended that care be based on the child's clinical presentation and on authorized policies and protocols.